FILED FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3452

Registration District No. 526 Primary Registration District No. 3030 Registrar's No. 9

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County MISSISSIPPI
(b) City or town CHARLESTON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 218 N. HEGGIE STREET (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community SINCE BIRTH

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County MISSISSIPPI
(c) City or town CHARLESTON (If outside city or town limits, write "RURAL")
(d) Street No. 218 N. HEGGIE STREET (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME IRLAND LAMB JR.
3. (b) If veteran, name war XXX
3. (c) Social Security No. XXX
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife XXX
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased APRIL (Month) 21 (Day) 1939 (Year)

8. AGE: Years 1 Months 9 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace CHARLESTON (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation INFANT
11. Industry or business XXX
12. Name of father IRLAND LAMB
13. Birthplace of father SIKESTON (City, town, or county) MISSOURI (State or foreign country)
14. Maiden name of mother ODIE BUNCH
15. Birthplace of mother WATER VALLEY (City, town, or county) KENTUCKY (State or foreign country)
16. (a) Informant ODIE LAMB
(b) Address 218 N. HEGGIE ST., CHARLESTON MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-28-41 (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK - SIKESTON, MO.
18. (a) Signature of funeral director Lair-Drummond Co.
(b) Address CHARLESTON, MISSOURI
19. (a) 1-28-41 (Date received local registrar) (b) J. L. Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 27 year 1941 hour 7 minute 45 A.M.
21. I hereby certify that I attended the deceased from JAN. 25, 1941, to JAN. 27, 1941; that I last saw him alive on JAN. 27, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia — Duration 1
Dehydration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. J. Huck (M. D. or other) DC
Address Charleston Mo Date signed 1-28-41

(Licensed Embalmer's Statement on Reverse Side)

107

RECEIVED
District Health Officer No. 2,
District File Number 241-1817
Date Filed 2/17/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
3-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 345-2

Registration District No. 566 Primary Registration District No. 30-30 Registrar's No.

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME. Irland Lamb Jr.
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 1 Months 9 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 4-10-41 (Date received local registrar) (b) F. A. Dunn (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Dehydration	
Due to No other Complications	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr C J Huck (M. D. or other) DC
Address Charleston Mo Date signed

SUPPLEMENTARY